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Unmet Expectations From Pregnancy Attributing to Post-Partum Depression: An Impact of Gender Discrimination

KEYWORDS: Post-partum depression, unmet expectations, pregnancy

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ABSTRACT *Post-partum depression is one of the commonest psychiatric disorders of pregnancy and puerperium. A number of etiological factors of bio-psycho-social origin attribute to post-partum depression. Mother's expectation from pregnancy also can be a big contributing factor for post-partum depression. In the male dominant society of Asia, a mother mostly expects a male child from her pregnancy and when her wishes were not met, a lot of psychological distress occurs. In this case report, we highlighted the unmet expectations of a mother leading to post-partum depression.*

Introduction

Post-partum depression is as common as 10 – 20% [1,2]. Women's life goes through a lot of phases of transitions and stress due to biological, psychological and social reasons in the different cultural contexts, which makes her more vulnerable to develop depression. Pregnancy and puerperium are such important, stressful transitions in a women's life. Stress in this period is directly related to the development of the depressive symptoms [1- 5]. Post-partum depression has almost similar core characteristics as that of major depressive disorder [6]. Additional things that are specifically seen in post – partum depression are lack of concern for the child, negative feelings towards the child which may amount to harm to the child [6]. Complex interplay of hormonal, psychological, female gender related vulnerability and other biological factors results in "Post-partum Depression". Failure in meeting the expectations of mother can be a reason for depression in post-partum period. In a male dominated society like India, irrespective of the number of females per thousand of males (940 females per 1000 males: Census of India, 2011) [7], most families or parents dream to have a male baby out of pregnancy. Gender discrimination leads to female feticide and seems to be the major reason of imbalance in the male female ratio which is not only a concern in India but also prevalent in most Asian countries [8]. The gender discrimination and bias usually starts from the family itself, as evidenced from the studies which revealed that beyond cultural and religious reasons, some societies have strong preference to have a son than a daughter [9, 10]. If the expectation to have a son is not met, it can be a significant stressor for the individual and the family.

Case Report

Mrs. S, 23 years old, married Muslim female of low socioeconomic status who was educated till class 10th had given birth to a female child approximately 8 months prior to her psychiatric hospitalization. Following the delivery of her baby girl, she was quite unhappy as she intensely wanted a male child. The delivery was an uncomplicated, normal vaginal delivery at term. Immediate post-partum period was uneventful. Over a period of next two weeks following delivery, it was reported that she was remaining persistently sad most part of the day with reduced interest in day to day activities and social interactions. She would lie on bed most of the time and was often seen crying. She often expressed guilt feelings for delivering a girl child and would seek reassurances from her husband and In-laws. There was significant impairment in day to day household work and care of baby. After repeated persuasion, she would feed and take care of the child. After 3 months, she started to talk irrelevantly, mutter to herself, observed to be smiling and laughing inappropriately by herself, was suspicious and fearful that someone around is trying to harm her, had referential ideas and had repeated ideation to harm self and her child. She tried to strangulate her child while feeding but was stopped by her in-laws and since then they have kept child separate from the mother in fear that she may harm the child again. She had decreased sleep, poor self-care and poor appetite. She also had frequent death wishes and had attempted thrice in last 2 months prior to hospitalization. After 3 months of onset of symptoms, she was shown to a private psychiatrist and was diagnosed as post-partum psychosis. She was treated with haloperidol 20 mg in divided doses and later with olanzapine 10 mg per day but was mostly non-compliant.

Her past and family history was not contributory. She had well-adjusted premorbid personality. On general physical and systemic examination, no abnormalities were found. On mental status examination, there was poor eye to eye contact, decreased speech flow, depressed affect, hopelessness, death wishes, ideas of reference, impaired judgment and absent insight. On the basis of history and mental status examination, a diagnosis of post – partum depression was made.

She was started on Fluoxetine 40 mg and Risperidone 4 mg, Trihexyphenidyl 2mg and clonazepam 0.5mg in divided doses. Over a period of 4 weeks, patient had shown noticeable improvement in depressive cognition and improvement in biological functions. Gradually antipsychotic Risperidone was tapered and stopped in the follow up. Supervised interaction of mother and child was encouraged. Psychoeducation about illness course, prognosis and management was done. Supportive sessions taken and she was allowed to ventilate. Over a period of 4 weeks' time, there was improvement of MADRS score from 50 to 24. She was discharged on the same medications.

Discussion

In this case, initial symptoms were not impairing so family members were little concerned about it. When she developed psychotic symptoms and tried to harm the baby, she was brought for consultation and focus on psychotic symptoms misguided the diagnosis. At that time patient's expectation from pregnancy and distress due to not having a male child was not explored. After she repeatedly attempted to harm herself, she was brought for hospitalization and detailed evaluation after hospitalization revealed her expectation of a male child, extreme frustration of having a female

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child and subsequent emergence of depressive symptoms.

After start of antidepressants and antipsychotics she had started showing improvement. Psychosocial issues were focused and the patient's expectations related to gender related issues were addressed.

Family member's lack of awareness about illness, misdiagnosis, treatment noncompliance and keeping aside the psychosocial issues resulted in long course (more than 9 months) of the illness.

Majority of Asian countries are developing countries with male dominant society. The society is mostly biased by gender discrimination, as a result of which male child is preferred over female child [8 – 10]. When the expectation of a male baby out of pregnancy is not met, it creates a lot of distress to the mother either directly as in our case, or indirectly due to family's distress, critical comments and at times physical abuses done by family members. Gender discrimination related stress has enormous impact on the psychological well-being, which can attribute to post-partum depression, as this period also carries a lot of biological and psycho-social vulnerabilities in a female. This stress has mostly been left unattended by the medical fraternity, particularly mental health professionals. It is now high time to be aware of and focus on such issues for possible prevention of gender biasing, discrimination and related stress.

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